



SIGNATURE PAGES

Program Support Bureau
Quality Assurance Division
County of Los Angeles – Department of Mental Health

Reviewer's Comments: _____

Reviewer's Signature/Discipline/Title

Printed Name of Reviewer

Date of Review

Reviewer's Signature/Discipline/Title

Printed Name of Reviewer

Date of Review

- Supervisor received Supervisee's QA Tool from QAC Chairperson: ☐ YES ☐ NO

Supervisor's Signature

Date

Supervisor's Comments: _____

Supervisor's Signature

Printed Name of Supervisor

Date

- Supervisor reviewed Corrective Action Plan with Supervisee: ☐ YES ☐ NO

Supervisor's Signature

Date

Supervisee's Signature

Date

Supervisee's Comments: _____

Supervisee's Signature

Printed Name of Supervisee

Date



SIGNATURE PAGES

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1. Corrective Action Plan completed/resolved by Supervisee: ☐ YES ☐ NO

Supervisee's Signature

Date

2. Completed/resolved Corrective Action Plan verified by Supervisor: ☐ YES ☐ NO

Supervisor's Signature

Date

3. Claim submitted for QA activities (SPMP only): ☐ YES ☐ NO

Reviewer's Signature

Date